

PHARMACIST/PRESCRIBER EMERGENCY CONTRACEPTION COLLABORATIVE PRACTICE PROTOCOL AND AGREEMENT

As a licensed health care provider authorized to prescribe medications in the State of New Hampshire, I authorize _____, R.Ph. to initiate emergency contraceptive drug therapy according to the protocol that follows. The protocol provides written guidelines for initiating drug therapy in accordance with the laws and regulations of the State of New Hampshire.

Purpose: Provide access to emergency contraception within the required time frame and to ensure the patient receives adequate information to successfully complete therapy.

Procedure: When the patient requests emergency contraception pills (ECP's), the pharmacist will assess the need for drug therapy and/or referral for contraceptive care. The pharmacist will determine the following:

- The date of the patient's last menstrual period to rule out established pregnancy.
- That the elapsed time since unprotected intercourse is less than 72 hours (or as agreed upon by collaborators).
- Whether the victim has been a victim of sexual assault.

Referrals: If EC drug therapy services are not available at the pharmacy, the patient will, if possible, be referred to another ECP provider or to the NH Planned Parenthood website for additional ECP provider information. The pharmacist should refer the patient to a health care provider or family planning office if established pregnancy cannot be ruled out.

If there is a concern that the patient may have contracted a sexually transmitted infection through unprotected sex and/or if the patient indicates that she has been sexually assaulted, the pharmacist will provide appropriate referral information while providing ECP's.

While ECP's can be used repeatedly without serious health risks, patients who request ECP's repeatedly will be referred to a health care provider or family planning office for follow-up.

Prophylactic Provision: The pharmacist may also dispense a course of ECP's to a patient in advance of the need for emergency contraception. In addition, the pharmacist will counsel the patient on available options for regular contraceptive methods or offer to refer the patient to a health care provider for additional contraceptive services.

ECP Product Selection: The pharmacist will only dispense medication from a list of products approved for emergency contraception and agreed upon as part of this agreement. The pharmacist should seek to provide the most effective ECP product to patients. The list will contain ECP's and adjunct medications for nausea and vomiting associated with EC drug therapy. The list will be maintained at the pharmacy and shared by all participants in the agreement. Along with the medications, patients will be provided with information concerning dosing, potential adverse effects, and follow-up contraceptive care.

Documentation and Quality Assurance: Each prescription initiated by the pharmacist will be documented in a patient profile as required by law and maintained at the pharmacy. EC therapy prescriptions and other patient information shall be provided the same confidentiality as all other patient records maintained at/by the pharmacy.

The pharmacist may, at the request of the patient, communicate information to the patient's primary care provider or for purposes of being referred to a practitioner as a new patient regarding her care relevant to emergency contraception drug therapy.

As may be established by both parties, the authorizing prescriber and the pharmacist should perform a quality assurance review of the decisions made according to mutually acceptable criteria.

The pharmacist named below has completed a specified training program approved by the New Hampshire Board of Pharmacy covering procedures listed above, the management of the sensitive communications often encountered in emergency contraception and the appropriate use of referral sources.

Authorized Prescriber's Signature: _____		Date: _____	
Authorized Prescriber's Printed Name: _____ <small>Type or Print Full Name</small>		NH Medical Lic. #: _____	
Authorized Prescriber's Office Address: _____ <small>Street Address</small>			
_____		_____	
<small>City</small>		<small>State</small>	<small>Zip Code</small>
Phone #: _____		Fax #: _____	
Licensed Pharmacist's Signature: _____		Date: _____	
Licensed Pharmacist's Printed Name: _____ <small>Type or Print Full Name</small>		NH Pharmacist Lic. #: _____	
Pharmacy Address: _____ <small>Street Address</small>			
_____		_____	
<small>City</small>		<small>State</small>	<small>Zip Code</small>
Phone #: _____		Fax #: _____	